SAMPLE

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION:

CRIMINAL JUSTICE SYSTEM REFERRAL

I, _____, authorize _____. to disclose to the
(Name of client) (Name of agency)
following person or organization below (Please check only one box per release and fill in contact name & information)

□ DWI Services & Division of MH & SA Services: _____
□ Probation/Parole Officer: _____
□ Mental Health or Substance Abuse Provider: _____
□ Court: _____ □ Prosecuting Attorney: _____
□ Defense Attorney: _____ □ Other: _____

to communicate with and disclose to one another the following information (nature and amount of the information as limited as possible):

__ my diagnosis, urinalysis results, information about my attendance or lack of attendance at treatment sessions, my cooperation with treatment program, prognosis, and

__ _____

The purpose of the disclosure is to inform the person(s) listed above of my attendance and progress in treatment.

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentially of Alcohol and Drug Abuse Patient Records, 42 C.F.R Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPPA), 45 C.F.R. Pts. 160 & 164. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires as follows:

___There has been a formal and effective termination or revocation of my release from confinement, probation, or parole, or other proceeding under which I was mandated into treatment, or

___There has been complete resolution of my DWI case(s), or

_____
(Specify other date, event, condition upon which consent expires)

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes. I have been provided a copy of this form.

_____ _____
Signature of client Date

_____
Signature of person signing form if not the patient

Describe authority to sign on behalf of patient: _____